

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2022

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 06/03/2022

- A** This return/report is for:
 - a multiemployer plan
 - a single-employer plan
 - a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
 - a DFE (specify) _____
- B** This return/report is:
 - the first return/report
 - the final return/report
 - an amended return/report
 - a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ▶
- D** Check box if filing under:
 - Form 5558
 - automatic extension
 - the DFVC program
 - special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

| | |
|--|---|
| 1a Name of plan <u>ABCOR 401(K) PLAN</u> | 1b Three-digit plan number (PN) ▶ <u>001</u> |
| | 1c Effective date of plan <u>08/01/2018</u> |
| 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>ALLIED SKILLED CARE INC</u> <u>3201 N WILKE RD</u> <u>ARLINGTON HEIGHTS, IL 60004-1437</u> | 2b Employer Identification Number (EIN) <u>36-4748168</u> |
| | 2c Plan Sponsor's telephone number <u>847-670-8268</u> |
| | 2d Business code (see instructions) <u>621610</u> |
| | |

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | |
|------------------|--|-------------------|--|
| SIGN HERE | <u>Filed with authorized/valid electronic signature.</u> | <u>10/26/2023</u> | <u>STEPHEN YOO</u> |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | <u>Filed with authorized/valid electronic signature.</u> | <u>10/26/2023</u> | <u>STEPHEN YOO</u> |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2022)
v. 220413

| | |
|--|---|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN 3c Administrator's telephone number |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN 4d PN |
| 5 Total number of participants at the beginning of the plan year | 5 579 |
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). | |
| 6(1) Total number of active participants at the beginning of the plan year | 6a(1) 560 |
| 6(2) Total number of active participants at the end of the plan year | 6a(2) 0 |
| b Retired or separated participants receiving benefits | 6b 0 |
| c Other retired or separated participants entitled to future benefits..... | 6c 0 |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d 0 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | 6e 0 |
| f Total. Add lines 6d and 6e | 6f 0 |
| g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... | 6g 0 |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | 6h 0 |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 |
| 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2E 2F 2G 2J 2T 3D | |
| b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: | |
| 9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | 9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor |
| 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) | |
| a Pension Schedules (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> 2 A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

| | | |
|---|--|--|
| <p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2022</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **06/03/2022**

| | | |
|---|--|-------------------|
| <p>A Name of plan ABCOR 401(K) PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>001</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 ALLIED SKILLED CARE INC</p> | <p>D Employer Identification Number (EIN) 36-4748168</p> | |

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
PRINCIPAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 42-0127290 | 61271 | 613953 | 92 | 01/01/2022 | 06/03/2022 |

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

| | |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 0 | 0 |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|----------|--|----------|---|
| 4 | Current value of plan's interest under this contract in the general account at year end..... | 4 | 0 |
| 5 | Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 0 |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

| | | | |
|----------|--|-----------|--|
| b | Premiums paid to carrier | 6b | |
| c | Premiums due but unpaid at the end of the year | 6c | |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶ | 6d | |

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶ CUSTODIAL GUARANTEED INTEREST CONTRACT

b Balance at the end of the previous year **7b** 1319

| | | | | |
|----------|--|--------------|-----|--|
| c | Additions: (1) Contributions deposited during the year | 7c(1) | 425 | |
| | (2) Dividends and credits..... | 7c(2) | | |
| | (3) Interest credited during the year..... | 7c(3) | 10 | |
| | (4) Transferred from separate account..... | 7c(4) | | |
| | (5) Other (specify below) | 7c(5) | | |

(6) Total additions..... **7c(6)** 435

d Total of balance and additions (add lines **7b** and **7c(6)**)..... **7d** 1754

e Deductions:

| | | |
|---|--------------|------|
| (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| (2) Administration charge made by carrier..... | 7e(2) | 2 |
| (3) Transferred to separate account..... | 7e(3) | |
| (4) Other (specify below) | 7e(4) | 1752 |

▶ MERGER

(5) Total deductions..... **7e(5)** 1754

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 0

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 8** Benefit and contract type (check all applicable boxes)
- | | | | |
|--|--|---|--|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts:

| | | | |
|---|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve..... | 9a(3) | | |
| (4) Earned ((1) + (2) - (3))..... | | 9a(4) | |
| b Benefit charges (1) Claims paid..... | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2))..... | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs..... | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges..... | 9c(1)(G) | | |
| (H) Total retention..... | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)..... | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement..... | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... | | 9e | |
| 10 Nonexperience-rated contracts: | | | |
| a Total premiums or subscription charges paid to carrier | | 10a | |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | 10b | |
| Specify nature of costs. | | | |

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

| | | |
|---|--|--|
| <p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2022</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **06/03/2022**

| | | |
|---|--|-------------------|
| <p>A Name of plan ABCOR 401(K) PLAN</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>001</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 ALLIED SKILLED CARE INC</p> | <p>D Employer Identification Number (EIN) 36-4748168</p> | |

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
PRINCIPAL LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 42-0127290 | 61271 | 721398 | 92 | 01/01/2022 | 06/03/2022 |

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

| | |
|---|--------------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 0 | 0 |

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
| | (c) Amount | (d) Purpose | |
| | | | |

| | |
|----------------|--|
| Part II | Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. |
|----------------|--|

| | | |
|---|----------|---|
| 4 Current value of plan's interest under this contract in the general account at year end..... | 4 | 0 |
| 5 Current value of plan's interest under this contract in separate accounts at year end..... | 5 | 0 |

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

| | | |
|---|-----------|--|
| b Premiums paid to carrier | 6b | |
| c Premiums due but unpaid at the end of the year | 6c | |
| d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶ | 6d | |

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

| | | |
|--|-----------|--|
| b Balance at the end of the previous year | 7b | |
|--|-----------|--|

| | | | |
|---|--------------|--|--|
| c Additions: (1) Contributions deposited during the year | 7c(1) | | |
| (2) Dividends and credits..... | 7c(2) | | |
| (3) Interest credited during the year..... | 7c(3) | | |
| (4) Transferred from separate account..... | 7c(4) | | |
| (5) Other (specify below) | 7c(5) | | |
| ▶ | | | |

| | | |
|--------------------------|--------------|--|
| (6) Total additions..... | 7c(6) | |
|--------------------------|--------------|--|

| | | |
|---|-----------|--|
| d Total of balance and additions (add lines 7b and 7c(6)) | 7d | |
|---|-----------|--|

| | | | |
|---|--------------|--|--|
| e Deductions: | | | |
| (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | | |
| (2) Administration charge made by carrier..... | 7e(2) | | |
| (3) Transferred to separate account..... | 7e(3) | | |
| (4) Other (specify below) | 7e(4) | | |
| ▶ | | | |

| | | |
|---------------------------|--------------|--|
| (5) Total deductions..... | 7e(5) | |
|---------------------------|--------------|--|

| | | |
|---|-----------|---|
| f Balance at the end of the current year (subtract line 7e(5) from line 7d) | 7f | 0 |
|---|-----------|---|

Part III Welfare Benefit Contract Information
 If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

- 8** Benefit and contract type (check all applicable boxes)
- | | | | |
|--|--|---|--|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts:

| | | | |
|---|-----------------|-----------------|--|
| a Premiums: (1) Amount received | 9a(1) | | |
| (2) Increase (decrease) in amount due but unpaid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium reserve..... | 9a(3) | | |
| (4) Earned ((1) + (2) - (3))..... | | 9a(4) | |
| b Benefit charges (1) Claims paid..... | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | 9b(2) | | |
| (3) Incurred claims (add (1) and (2))..... | | 9b(3) | |
| (4) Claims charged | | 9b(4) | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | |
| (A) Commissions | 9c(1)(A) | | |
| (B) Administrative service or other fees | 9c(1)(B) | | |
| (C) Other specific acquisition costs..... | 9c(1)(C) | | |
| (D) Other expenses | 9c(1)(D) | | |
| (E) Taxes | 9c(1)(E) | | |
| (F) Charges for risks or other contingencies | 9c(1)(F) | | |
| (G) Other retention charges..... | 9c(1)(G) | | |
| (H) Total retention..... | | 9c(1)(H) | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)..... | | 9c(2) | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement..... | | 9d(1) | |
| (2) Claim reserves | | 9d(2) | |
| (3) Other reserves | | 9d(3) | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... | | 9e | |
| 10 Nonexperience-rated contracts: | | | |
| a Total premiums or subscription charges paid to carrier | | 10a | |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount | | 10b | |
| Specify nature of costs. | | | |

Part IV Provision of Information

- 11** Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No
- 12** If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE C
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2022

This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 06/03/2022

| | | |
|---|--|------------|
| A Name of plan <u>ABCOR 401(K) PLAN</u> | B Three-digit plan number (PN) ▶ | <u>001</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>ALLIED SKILLED CARE INC</u> | D Employer Identification Number (EIN) <u>36-4748168</u> | |

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

PRINCIPAL LIFE INSURANCE COMPANY

42-0127290

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

PRINCIPAL LIFE INSURANCE COMPANY

42-0127290

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 50 64 | CONTRACT ADMINISTRATOR | 1049 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

(a) Enter name and EIN or address (see instructions)

WILSHIRE ADVISORS LLC

95-2755361

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 27 72 | INVESTMENT ADVISORY | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

(a) Enter name and EIN or address (see instructions)

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
|---|--|---|
| WILSHIRE ADVISORS LLC | 27 72 | 0 |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| PRINCIPAL LIFE INSURANCE COMPANY 42-0127290 | 1 BASIS POINT ANNUALLY ON ELIGIBLE PLAN ASSETS IN WILSHIRE 3(21) OR WILSHIRE 3(21) AUTO-EXECUTE FIDUCIARY SERVICE. | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| | | |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| | | |
| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
| | | |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. | |
| | | |

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|---|--------------------------------------|--|
| | | |

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |

Explanation:

| | |
|--------------------|---------------------|
| a Name: | b EIN: |
| c Position: | |
| d Address: | e Telephone: |

Explanation:

| | | |
|---|--|--|
| SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> | DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. | OMB No. 1210-0110 <hr/> 2022 This Form is Open to Public Inspection. |
|---|--|--|

| | | |
|--|---|------------|
| For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 06/03/2022 | | |
| A Name of plan ABCOR 401(K) PLAN | B Three-digit plan number (PN) ▶ | 001 |
| C Plan or DFE sponsor's name as shown on line 2a of Form 5500 ALLIED SKILLED CARE INC | | |
| D Employer Identification Number (EIN) 36-4748168 | | |

| | |
|---------------|--|
| Part I | Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs) |
|---------------|--|

| | | | |
|---|--|---|----------|
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN DIVERSIFIED INTL SA-Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL LIFE INSURANCE COMPANY | | |
| c EIN-PN 42-0127290-015 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN LGCP S&P 500 INDEX SA-Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL LIFE INSURANCE COMPANY | | |
| c EIN-PN 42-0127290-016 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN SMCAP S&P 600 INDEX SA-Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL LIFE INSURANCE COMPANY | | |
| c EIN-PN 42-0127290-028 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN MIDCAP S&P 400 IDX SA-Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL LIFE INSURANCE COMPANY | | |
| c EIN-PN 42-0127290-023 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN REAL ESTATE SECS SA-Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL LIFE INSURANCE COMPANY | | |
| c EIN-PN 42-0127290-095 | d Entity code P | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN LIFETIME HYBR 2010 CIT Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-001 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: | PRIN LIFETIME HYBR 2015 CIT Z | | |
| b Name of sponsor of entity listed in (a): | PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-002 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) | 0 |

| | | |
|---|------------------------|---|
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2020 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-003 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2025 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-004 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2030 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-005 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2035 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-006 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2040 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-007 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2045 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-008 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2050 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-009 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2055 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-010 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR INC CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-011 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
| a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2060 CIT Z | | |
| b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO | | |
| c EIN-PN 26-6447574-012 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |

a Name of MTIA, CCT, PSA, or 103-12 IE: PRIN LIFETIME HYBR 2065 CIT Z

b Name of sponsor of entity listed in (a): PRINCIPAL GLOBAL INVESTORS TRUST CO

| | | |
|--------------------------------|------------------------|---|
| c EIN-PN 26-6447574-013 | d Entity code C | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0 |
|--------------------------------|------------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

| | | |
|-----------------|----------------------|---|
| c EIN-PN | d Entity code | e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|---|

| | | |
|---|---|--|
| <p style="text-align: center;">SCHEDULE H (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Financial Information</p> <p style="font-size: small;">This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).</p> <p>► File as an attachment to Form 5500.</p> | <p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2022</p> <hr/> <p style="font-size: small;">This Form is Open to Public Inspection</p> |
|---|---|--|

For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **06/03/2022**

| | |
|---|--|
| <p>A Name of plan ABCOR 401(K) PLAN</p> | <p>B Three-digit plan number (PN) ► 001</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 ALLIED SKILLED CARE INC</p> | <p>D Employer Identification Number (EIN) 36-4748168</p> |

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

| Assets | (a) Beginning of Year | (b) End of Year |
|---|-----------------------|-----------------|
| a Total noninterest-bearing cash..... | 1a | |
| b Receivables (less allowance for doubtful accounts): | | |
| (1) Employer contributions..... | 1b(1) | 3409 |
| (2) Participant contributions..... | 1b(2) | 6037 |
| (3) Other..... | 1b(3) | |
| c General investments: | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit)..... | 1c(1) | |
| (2) U.S. Government securities..... | 1c(2) | |
| (3) Corporate debt instruments (other than employer securities): | | |
| (A) Preferred..... | 1c(3)(A) | |
| (B) All other..... | 1c(3)(B) | |
| (4) Corporate stocks (other than employer securities): | | |
| (A) Preferred..... | 1c(4)(A) | |
| (B) Common..... | 1c(4)(B) | |
| (5) Partnership/joint venture interests..... | 1c(5) | |
| (6) Real estate (other than employer real property)..... | 1c(6) | |
| (7) Loans (other than to participants)..... | 1c(7) | |
| (8) Participant loans..... | 1c(8) | |
| (9) Value of interest in common/collective trusts..... | 1c(9) | 502113 |
| (10) Value of interest in pooled separate accounts..... | 1c(10) | 185948 |
| (11) Value of interest in master trust investment accounts..... | 1c(11) | |
| (12) Value of interest in 103-12 investment entities..... | 1c(12) | |
| (13) Value of interest in registered investment companies (e.g., mutual funds)..... | 1c(13) | 397605 |
| (14) Value of funds held in insurance company general account (unallocated contracts)..... | 1c(14) | 1319 |
| (15) Other..... | 1c(15) | |

| 1d Employer-related investments: | | (a) Beginning of Year | (b) End of Year |
|---|-------|-----------------------|-----------------|
| (1) Employer securities..... | 1d(1) | | |
| (2) Employer real property..... | 1d(2) | | |
| e Buildings and other property used in plan operation..... | 1e | | |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 1096431 | 0 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | | |
| h Operating payables..... | 1h | | |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | | |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 0 | 0 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 1096431 | 0 |

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

| Income | | (a) Amount | (b) Total |
|--|----------|------------|-----------|
| a Contributions: | | | |
| (1) Received or receivable in cash from: (A) Employers..... | 2a(1)(A) | 28073 | |
| (B) Participants..... | 2a(1)(B) | 60279 | |
| (C) Others (including rollovers)..... | 2a(1)(C) | 1143 | |
| (2) Noncash contributions..... | 2a(2) | | |
| (3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)..... | 2a(3) | | 89495 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | | |
| (B) U.S. Government securities..... | 2b(1)(B) | | |
| (C) Corporate debt instruments..... | 2b(1)(C) | | |
| (D) Loans (other than to participants)..... | 2b(1)(D) | | |
| (E) Participant loans..... | 2b(1)(E) | | |
| (F) Other..... | 2b(1)(F) | 10 | |
| (G) Total interest. Add lines 2b(1)(A) through (F)..... | 2b(1)(G) | | 10 |
| (2) Dividends: | | | |
| (A) Preferred stock..... | 2b(2)(A) | | |
| (B) Common stock..... | 2b(2)(B) | | |
| (C) Registered investment company shares (e.g. mutual funds)..... | 2b(2)(C) | 793 | |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C)..... | 2b(2)(D) | | 793 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)..... | 2b(5)(C) | | |

| | | (a) Amount | (b) Total |
|---|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts | 2b(6) | | -68431 |
| (7) Net investment gain (loss) from pooled separate accounts | 2b(7) | | -23723 |
| (8) Net investment gain (loss) from master trust investment accounts | 2b(8) | | |
| (9) Net investment gain (loss) from 103-12 investment entities..... | 2b(9) | | |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) | 2b(10) | | -77425 |
| c Other income | 2c | | |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | -79281 |
| Expenses | | | |
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 107693 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | | |
| (3) Other | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3)..... | 2e(4) | | 107693 |
| f Corrective distributions (see instructions)..... | 2f | | |
| g Certain deemed distributions of participant loans (see instructions) | 2g | | |
| h Interest expense..... | 2h | | |
| i Administrative expenses: (1) Professional fees | 2i(1) | | |
| (2) Contract administrator fees..... | 2i(2) | 1050 | |
| (3) Investment advisory and management fees | 2i(3) | 1336 | |
| (4) Other | 2i(4) | | |
| (5) Total administrative expenses. Add lines 2i(1) through (4)..... | 2i(5) | | 2386 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 110079 |
| Net Income and Reconciliation | | | |
| k Net income (loss). Subtract line 2j from line 2d..... | 2k | | -189360 |
| l Transfers of assets: | | | |
| (1) To this plan | 2l(1) | | |
| (2) From this plan..... | 2l(2) | | 907071 |

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

- (1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

- (1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: ELENA OLSHANSKY

(2) EIN: 82-5386415

d The opinion of an independent qualified public accountant is **not attached** because:

- (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)

| | Yes | No | Amount |
|----|-----|----|--------|
| 4a | | X | |

| | | Yes | No | Amount |
|---|-----------|-----|----|--------|
| b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)..... | 4b | | X | |
| c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) | 4c | | X | |
| d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)..... | 4d | | X | |
| e Was this plan covered by a fidelity bond?..... | 4e | | X | |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | 4f | | X | |
| g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?..... | 4g | | X | |
| h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?..... | 4h | | X | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)..... | 4i | | X | |
| j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)..... | 4j | | X | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?..... | 4k | X | | |
| l Has the plan failed to provide any benefit when due under the plan?..... | 4l | | X | |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)..... | 4m | X | | |
| n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3..... | 4n | X | | |

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... Yes No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year 0.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

| 5b(1) Name of plan(s) | 5b(2) EIN(s) | 5b(3) PN(s) |
|------------------------------|--------------|-------------|
| SHEPERD POOLED EMPLOYER PLAN | 41-4142669 | 001 |
| | | |
| | | |
| | | |

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

| | | |
|--|---|---|
| SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 2022 This Form is Open to Public Inspection. |
|--|---|---|

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 06/03/2022

| | | |
|---|--|------------|
| A Name of plan <u>ABCOR 401(K) PLAN</u> | B Three-digit plan number (PN) ▶ | <u>001</u> |
| C Plan sponsor's name as shown on line 2a of Form 5500 <u>ALLIED SKILLED CARE INC</u> | D Employer Identification Number (EIN) <u>36-4748168</u> | |

| | |
|---------------|----------------------|
| Part I | Distributions |
|---------------|----------------------|

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....

| | |
|---|---|
| 1 | 0 |
|---|---|

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
EIN(s): 42-0127290

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....

| | |
|---|--|
| 3 | |
|---|--|

| | |
|----------------|---|
| Part II | Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.) |
|----------------|---|

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

| | | |
|---|-----------|--|
| 6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)..... | 6a | |
| b Enter the amount contributed by the employer to the plan for this plan year..... | 6b | |
| c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)..... | 6c | |

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? Yes No N/A

| | |
|-----------------|-------------------|
| Part III | Amendments |
|-----------------|-------------------|

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... Increase Decrease Both No

| | |
|----------------|---|
| Part IV | ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|----------------|---|

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?..... Yes No

11 a Does the ESOP hold any preferred stock?..... Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)..... Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market?..... Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____ **c** Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

| | | |
|---|------------|--|
| a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: <input type="checkbox"/> last contributing employer <input type="checkbox"/> alternative <input type="checkbox"/> reasonable approximation (see instructions for required attachment)..... | 14a | |
| b The plan year immediately preceding the current plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment) | 14b | |
| c The second preceding plan year. <input type="checkbox"/> Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)..... | 14c | |

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

| | | |
|--|------------|--|
| a The corresponding number for the plan year immediately preceding the current plan year..... | 15a | |
| b The corresponding number for the second preceding plan year..... | 15b | |

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

| | | |
|---|------------|--|
| a Enter the number of employers who withdrew during the preceding plan year | 16a | |
| b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers..... | 16b | |

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment

19 If the total number of participants is 1,000 or more, complete lines (a) through (c)

a Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
 0-3 years 3-6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-21 years 21 years or more

c What duration measure was used to calculate line 19(b)?
 Effective duration Macaulay duration Modified duration Other (specify): _____

20 PBGC missed contribution reporting requirements. If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? Yes No

b If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation _____

NORTHWEST HOME CARE, INC.
dba ABCOR HOME HEALTH, INC.
ANNUAL FINANCIAL REPORT
TWELVE MONTHS ENDED
DECEMBER 31, 2022

Elena Y. Olshansky
Certified Public Accountant
Skokie, IL 60077

NORTHWEST HOME CARE, INC.
dba ABCOR HOME HEALTH, INC.
ANNUAL FINANCIAL REPORT

CONTENTS

| <u>DESCRIPTION</u> | <u>PAGE</u> |
|---|-------------|
| Independent Auditor's Report | 2-3 |
| Balance Sheet | 4 |
| Statement of Income and Retained Earnings | 5 |
| Statement of Cash Flows | 6 |
| Notes to Financial Statements | 7-10 |
| Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards | 11-12 |
| Supplemental Information Consolidated Year-End Financial Report | 13-16 |
| Copy of a Public Accountant license | 17 |

ELENA Y. OLSHANSKY, CPA

8324 LINCOLN AVE
SKOKIE, IL 60077
Tel. 847-568-1442 Fax. 847-868-3693

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
of Northwest Home Care, Inc.
dba Abcor Home Health, Inc.
Arlington Heights, IL

Opinion

We have audited the financial statements of Northwest Home Care, Inc. dba Abcor Home Health, Inc. which comprise the balance sheets as of December 31, 2022, and the related statements of income, changes in stockholders' equity, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Northwest Home Care, Inc. dba Abcor Home Health, Inc. as of December 31, 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Northwest Home Care, Inc. dba Abcor Home Health, Inc. and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Northwest Home Care, Inc. dba Abcor Home Health, Inc.'s ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is

(continued)

not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Northwest Home Care, Inc. dba Abcor Home Health, Inc.'s internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Northwest Home Care, Inc. dba Abcor Home Health, Inc.'s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Other Reporting Required by Government Auditing Standards

In accordance with Government Auditing Standards, we have also issued our report dated June 29, 2023 on our consideration of Northwest Home Care, Inc. dba Abcor Home Health, Inc. internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering Northwest Home Care, Inc. dba Abcor Home Health, Inc. internal control over financial reporting and compliance.

In relation to opinion

Our audit was performed for the purpose of forming an opinion on the basic financial statements of Northwest Home Care, Inc. dba Abcor Home Health, Inc. taken as a whole. The supplementary information following page 12 including the “Schedules of Program Costs and Program Revenues of the Consolidated Financial Report” for the State of Illinois Fiscal Year ended December 31, 2022 is presented for purposes of additional analysis as required by the Illinois Department of Human Services and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the financial statements referred to above and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.



Skokie, IL
July 12, 2023

NORTHWEST HOME CARE, INC.
dba ABCOR HOME HEALTH, INC.
BALANCE SHEET
Twelve months ended December 31, 2022

ASSETS

CURRENT ASSETS

| | | |
|---|----|-----------|
| Cash and cash equivalents | \$ | 3,360,706 |
| Accounts and notes receivable, net of valuation allowance | | 4,854,816 |
| Prepaid expenses | | 71,181 |
| Right-of-use assets ST | | 41,905 |
| Inventory | | 93,689 |

Total current assets 8,422,297

PROPERTY AND EQUIPMENT, NET

51,504

OTHER ASSETS

| | | |
|---------------|--|---------|
| Software, net | | 727,751 |
|---------------|--|---------|

Total other assets 727,751

TOTAL ASSETS \$ 9,201,552

LIABILITIES AND OWNER'S EQUITY

CURRENT LIABILITIES

| | | |
|--|----|---------|
| Accounts payable and accrued expenses | \$ | 69,223 |
| IL Replacement tax payable | | 28,605 |
| Lease liabilities ST | | 41,905 |
| Payroll and payroll taxes withheld and accrued | | 711,385 |

Total current liabilities 851,118

LONG TERM LIABILITIES

-

TOTAL LIABILITIES 851,118

SHAREHOLDER'S EQUITY

| | | |
|-------------------|--|-----------|
| Common stock | | 1,000 |
| Retained earnings | | 8,349,434 |

Total shareholder's equity 8,350,434

TOTAL LIABILITIES AND SHAREHOLDER'S EQUITY \$ 9,201,552

The accompanying notes are an integral part of these financial statements

NORTHWEST HOME CARE, INC.
dba ABCOR HOME HEALTH, INC.
STATEMENT OF INCOME AND RETAINED EARNINGS
Twelve months ended December 31, 2022

| | |
|--|---------------------|
| REVENUE | |
| Service fees, net | \$ 25,554,109 |
| Total revenue | <u>25,554,109</u> |
| COST OF GOODS SOLD | |
| Advertising and marketing | 201,361 |
| Licenses, permits and fees | 44,221 |
| Billing and support services | 3,388,507 |
| Total cost of goods sold | <u>3,634,089</u> |
| Gross Income | <u>21,920,020</u> |
| OPERATING EXPENSES | |
| Amortization | 439,832 |
| Bad debt expense | 184,895 |
| Continuing education and recruiting | 253,319 |
| Depreciation expense | 31,553 |
| Employees benefits | 279,358 |
| Insurance expense | 32,533 |
| Workers' compensation insurance | 222,571 |
| Office expense | 68,239 |
| Officers' salary | 295,000 |
| Outside contractors | 240,343 |
| Payroll tax expense | 1,747,650 |
| Pension plan contributions | 82,533 |
| Professional fees | 281,482 |
| Rent | 512,393 |
| Repairs and maintenance | 61,816 |
| Salaries and wages | 15,318,047 |
| Supplies | 65,989 |
| Telephone and internet | 117,510 |
| Travel and auto expenses | 57,047 |
| Utilities | 32,571 |
| Total operating expenses | <u>20,324,681</u> |
| Net Income from operations | 1,595,339 |
| OTHER INCOME | |
| Other income | 123,428 |
| Interest income (expense) | <u>6,303</u> |
| Total other income (expense) | 129,731 |
| NET INCOME BEFORE INCOME TAXES | 1,725,070 |
| PROVISION FOR STATE INCOME TAXES | <u>(28,605)</u> |
| NET INCOME | 1,696,465 |
| RETAINED EARNINGS, at January 1, 2022 | 8,030,251 |
| Less distributions to stockholder | <u>(1,377,282)</u> |
| RETAINED EARNINGS, at December 31, 2022 | <u>\$ 8,349,434</u> |

The accompanying notes are an integral part of these financial statements

NORTHWEST HOME CARE, INC.
dba ABCOR HOME HEALTH, INC.
STATEMENT OF CASH FLOWS
Twelve months ended December 31, 2022

| | |
|--|----------------------------|
| CASH FLOW FROM OPERATING ACTIVITIES | |
| Net Income | \$ 1,696,465 |
| Adjustments to reconcile Net income to net cash provided by operating activities: | |
| Increase in Accounts and notes receivable | (175,541) |
| Decrease in Prepaid expenses | 91,129 |
| Depreciation and amortization | 471,385 |
| Decrease in Accounts payable and accrued expenses | (655,252) |
| Decrease in Unearned revenues | (67,287) |
| Decrease in Inventory | 6,299 |
| Decrease in Payroll and payroll tax withheld and accrued | (9,265) |
| Decrease in IL replacement tax payable | (15,370) |
| | <hr/> |
| Net cash provided (used) in operating activities | 1,342,563 |
| CASH FLOW FROM INVESTING ACTIVITIES | |
| Acquisition and retirement of property and equipment | (519,513) |
| CASH FLOW FROM FINANCING ACTIVITIES | |
| Distributions to stockholders | (1,377,282) |
| Right-of-use assets ST | 41,905 |
| Lease liabilities ST | (41,905) |
| | <hr/> |
| Net cash provided (used) by financing activities | (1,377,282) |
| Increase (decrease) in cash | (554,232) |
| CASH, at January 1, 2022 | 3,914,938 |
| CASH, at December 31, 2022 | <u><u>\$ 3,360,706</u></u> |
| Supplemental disclosure of Cash flow information | |
| Cash paid during the year for Interest | <u><u>\$ -</u></u> |
| Income taxes | <u><u>\$ 43,975</u></u> |

The accompanying notes are an integral part of these financial statements

NORTHWEST HOME CARE, INC.

dba ABCOR HOME HEALTH, INC.

Notes to Financial Statements Year Ended December 31, 2022

Note 1- Summary of Significant Accounting Policies

Nature of business

Northwest Home Care, Inc. (the Company) is a for profit corporation organized under the State of Illinois Business Corporation Act on June 14, 2005. The Company is engaged in the business of in-home care mostly to the elderly and disabled. The Company is licensed with Illinois Department of public health as Home Services Agency and Home Services Placement Agency. The Company also holds the Home Health Care provider license.

Basis of Accounting

The Company prepares its financial statements on the accrual basis of accounting in accordance with generally accepted accounting principles.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that effect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Revenue Recognition

Northwest Home Care, Inc. recognizes income and corresponding receivable on the completion of the following: services have been provided to the clients and have been approved by the program.

Accounts Receivable and allowance for doubtful accounts

The Company provides an allowance for doubtful accounts equal to the estimated uncollectible accounts. The Company's estimate is based on historical collections and a review of the current status of accounts receivable. In the year 2022 the amount of 184,895 was written off as a bad debt as it became uncollectible.

Income Taxes

The company with the consent of its shareholders has elected to be treated as a Small Business Corporation (S corporation) under Internal Revenue Code section 1362. This election provides that, in lieu of corporate income taxes, the taxable items and credits pass directly to the stockholders. Therefore, these financial statements do not include federal income taxes which would otherwise be applicable.

Management does not believe that any material uncertain tax position exists to subject the company to the examination by Federal or state tax authorities for a period of three years from the date they have filed corporate income taxes. IL Replacement Income taxes expense for the Year 2022 was \$28,605.

Fair Value of Financial Instruments

The fair value of financial instruments including cash and cash equivalents, accounts receivable, prepaid expenses, accounts payable and accrual expenses, warehouse loans held for sale and

Notes to Financial Statements (continued)

corresponding line of credit approximates the varying values principally because of the short maturity of those items.

Concentration of Credit Risk

The Company does not hold neither substantial Long Term obligations nor substantial Accounts Receivable. The Company's credit balances are paid monthly in full. It appears the company currently has zero balance credit risk.

Note 2 - Assets

Cash and Cash Equivalents

Cash and cash equivalents consist of highly liquid investments, including operating and payroll accounts at US Bank, Chase bank and Harris bank. In the year 2022 \$250,000 of the above funds in each bank has been insured by the individual banks through FDIC.

Fixed Assets

Property and equipment are stated at cost less accumulated depreciation. Depreciation is provided over the estimated useful lives ranging from 5 to 7 years of the assets, principal using the straight-line method, for financial reporting purposes.

Property and equipment, net consist of the following:

| | December 31, 2022 |
|-------------------------------|-------------------|
| Equipment | \$ 143,688 |
| Office furniture | 30,561 |
| Company's vehicle | 47,787 |
| Lease Hold Improvements | <u>54,318</u> |
| | 276,354 |
| Less accumulated depreciation | <u>(224,850)</u> |
| Net Fixed assets | <u>\$ 51,504</u> |
| Depreciation expense, 2022 | <u>\$ 31,553</u> |

Other Assets consist of the following:

| | December 31, 2022 |
|------------------------------------|-------------------|
| Software | \$ 1,634,076 |
| Accumulated amortization, software | <u>(906,325)</u> |
| Software, net | <u>727,751</u> |
| Amortization expense, 2022 | <u>\$439,832</u> |

Note 3 - Liabilities

The short term liabilities comprise of the Accounts payable, credit cards payable, bills, payroll and, other taxes accrued, but not yet paid. In the year 2022 the Company had Business Lines of credit with Bank financial, principal \$2,500,000, interest rate 5% opened May 11, 2018,

Notes to Financial Statements (continued)

renewed July 11, 2023. Balance at December 31, 2022 was 0. Total interest paid in the Year 2022 on Lines of Credit was \$0.

Note 4 - Capital stock

Authorized: 3,000 shares of common stock. Issued: 100 shares of common stock for the total consideration of \$200.

Note 5 – Revenues breakdown by program

| | |
|--|---------------------|
| Revenues, CCP Program, billed and approved in 2022 | \$ 12,635,925 |
| Revenues, DHS Program | 583,746 |
| Revenues, Medicare | 549,958 |
| Revenues, MCO | 11,702,041 |
| Revenues, other | <u>82,439</u> |
| Total Revenues, net | <u>\$25,554,109</u> |

Note 6 - Interest income (expense), net and Other income, net

Company had Interest income paid by Insurance companies in the amount of \$6,303.

Other income consists of health stimulus reimbursements in connection with Covid-19 in the amount of 123,428.

Note 8 – Distributions to the stockholders

Distributions to the S corporation stockholder are made from the Accumulated Adjustment Account after the Income has been previously taxed to the stockholders, in proportion to their ownership.

Note 9 – Lease Commitments

During the year of 2022 the company had seven locations and leased three of its offices from the unrelated parties with the monthly rent amount for: Woodridge office - \$1,070 1 year lease, to be renewed in October 2023; Rockford office - \$870 per month was 1 year lease to be renewed in February 2023, Woodridge office \$1,070 per month 1 year lease to be renewed in February 2023, a Midwest 1 year lease 1,000 per month. The company's headquarters are located in 3201 N. Wilke Rd Arlington Heights, IL 60004 in the building owned by the Ancor Services, LLC. The new Chicago location is also owned by Ancor Services, LLC. see Note 10 Related parties' transactions.

In accordance with ASC 842 standard issued by the FASB re the new lease accounting in effect for the calendar year 2022, the company recorded: ST and LT Right-of-use assets and corresponding ST and LT Lease Liability for the office and two company vehicles. The third company vehicle lease expired as of December of 2022.

Office: ST Right-of-use assets and corresponding Lease Liability was \$41,905;
 LT Right-of-use assets and corresponding Lease Liability was \$41,905

The company leases software needed for its operations from four unrelated companies under 3 years' operating leases. Average Monthly lease payments were \$20,636.

Office Rent expense was \$264,757 for the year ended December 31, 2022, software lease was 247,636.

Note 10 – Related parties transactions

The Company's headquarters and office in Chicago both are leased from the Ancor Services, LLC owned by the owners of the company in accordance with the Lease agreement structured as an arm-length transaction. In 2022 the company paid to Ancor Services, LLC the amount of \$222,852 i.e. \$18,571 per month for three offices, including payments for the Real estate taxes. The company has valid contracts with related parties Arstar Home Health, Inc. and Allied Skilled Care, Inc. The terms of the contracts are on the arm-length transaction basis. Office staff of the company are employees of both companies and contracted by Northwest Home Care, Inc to provide administrative and staffing services both agreements are in compliance with "HIPPA" act of 1996. Office staff monitors provision of services according to the Client's Plan of Care, giving out homemaker assignments, monitoring staffing needs and employee's performances.

The company currently is in the process of separating from one of its shareholders. There was a company valuation, and miscellaneous legal expenses incurred as a result. The probability of business continuation in connection with appears not to be affected.

Note 11 - Breakdown of Cost Categories for In-home Service

in accordance with title 89: social services chapter ii: department on aging part 240 community care program section 240.2040 cost categories for in-home service, the Providers are required to expend a min of 77% of the total revenues due from the Department to include the client incurred expense for direct service worker costs, as enumerated in Section 240.2050, during a reporting year. The remaining 23% of the total revenues may be spent by the provider agencies at their discretion on administrative or program support costs, also delineated in Section 240.2050. As of December 31, 2022 the Company did adhere to these requirements.

Note 12 - Subsequent events

The management of the company have reviewed the results of operations and evaluated subsequent events from the period at time from its year end December 31, 2022 through July 12, 2023 the date the Financial statements were available to be issued and have determined that no adjustments are necessary to the amounts reported in the accompanying financial statements nor have any subsequent events occurred, the nature of which would require disclosure.

Independent Auditor’s Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

To the Board of Directors
of Northwest Home Care, Inc.
dba Abcor Home Health, Inc.
Arlington Heights, IL

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the financial statements of Northwest Home Care, Inc. dba Abcor Home Health, Inc., which comprise the balance sheet as of December 31, 2022, and the related statements of income and expense, retained earnings, and cash flows for the year then ended and the related notes to the financial statements, and have issued our report thereon June 29, 2023.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered Northwest Home Care, Inc. dba Abcor Home Health, Inc. internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Northwest Home Care, Inc. dba Abcor Home Health, Inc. internal control. Accordingly, we do not express an opinion on the effectiveness of Northwest Home Care, Inc. dba Abcor Home Health, Inc. internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. *A material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity’s financial statements will not be prevented, or detected and corrected, on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

(continued)

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Northwest Home Care, Inc. dba Abcor Home Health, Inc. financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "E. Olshansky", with a long horizontal flourish extending to the right.

Elena Y. Olshansky

Skokie, IL

July 12, 2023.

**Illinois Grant Accountability and Transparency
Consolidated Year-End Financial Report**

| | |
|----------------------|--|
| Grantee Name | Northwest Home Care Inc |
| ID Numbers | AUDIT:30683 Grantee:681247 UEI:C5CRKAN2U1G3 FEIN:203030621 |
| Audit Period | 1/1/2022 - 12/31/2022 |
| Submitted | 07/14/2023; Stephen yoo; Controller; stephen.yoo@abcor.com; 847-680-8268x170 |
| Accepted | |
| Program Count | 1 |

| All Programs Total | | | | |
|--|----------------------|----------------|----------------------|----------------------|
| Category | State | Federal | Other | Total |
| Personal Services (Salaries and Wages) | 8,310,694.00 | 0.00 | 7,089,975.00 | 15,400,669.00 |
| Fringe Benefits | 192,495.00 | 0.00 | 36,863.00 | 229,358.00 |
| Travel | 15,868.00 | 0.00 | 41,179.00 | 57,047.00 |
| Equipment | 0.00 | 0.00 | 0.00 | 0.00 |
| Supplies | 0.00 | 0.00 | 65,989.00 | 65,989.00 |
| Contractual Services | 0.00 | 0.00 | 224,932.00 | 224,932.00 |
| Consultant (Professional Services) | 0.00 | 0.00 | 281,482.00 | 281,482.00 |
| Construction | 0.00 | 0.00 | 0.00 | 0.00 |
| Occupancy - Rent and Utilities | 0.00 | 0.00 | 277,433.00 | 277,433.00 |
| Research and Development | 0.00 | 0.00 | 0.00 | 0.00 |
| Telecommunications | 0.00 | 0.00 | 87,475.00 | 87,475.00 |
| Training and Education | 0.00 | 0.00 | 0.00 | 0.00 |
| Direct Administrative Costs | 1,117,175.00 | 0.00 | 287,186.00 | 1,404,361.00 |
| Miscellaneous Costs | 82,233.00 | 0.00 | 4,581,051.00 | 4,663,284.00 |
| All Grant Specific Categories | 0.00 | 0.00 | 0.00 | 0.00 |
| TOTAL DIRECT EXPENDITURES | 9,718,465.00 | 0.00 | 12,973,565.00 | 22,692,030.00 |
| Indirect Costs | 1,266,740.00 | 0.00 | 0.00 | 1,266,740.00 |
| TOTAL EXPENDITURES | 10,985,205.00 | 0.00 | 12,973,565.00 | 23,958,770.00 |

**Illinois Grant Accountability and Transparency
Consolidated Year-End Financial Report**

| | |
|----------------------------|--------------------------------------|
| State Agency | Department On Aging (402) |
| Program Name | Community Care Program (402-04-1452) |
| Program Limitations | No |
| Mandatory Match | No |
| Indirect Cost Rate | 0.00 Base: |

| Category | State | Federal | Other | Total |
|--|----------------------|----------------|--------------|----------------------|
| Personal Services (Salaries and Wages) | 8,310,694.00 | 0.00 | 0.00 | 8,310,694.00 |
| Fringe Benefits | 192,495.00 | 0.00 | 0.00 | 192,495.00 |
| Travel | 15,868.00 | 0.00 | 0.00 | 15,868.00 |
| Direct Administrative Costs | 1,117,175.00 | 0.00 | 0.00 | 1,117,175.00 |
| Miscellaneous Costs | 82,233.00 | 0.00 | 0.00 | 82,233.00 |
| Indirect Costs | 1,266,740.00 | 0.00 | 0.00 | 1,266,740.00 |
| TOTAL DIRECT EXPENDITURES | 10,985,205.00 | 0.00 | 0.00 | 10,985,205.00 |

**Illinois Grant Accountability and Transparency
Consolidated Year-End Financial Report**

| | |
|---------------------|-------------------------------------|
| Program Name | Other grant programs and activities |
|---------------------|-------------------------------------|

| Category | State | Federal | Other | Total |
|----------------------------------|--------------|----------------|--------------|--------------|
| | 0.00 | 0.00 | 0.00 | 0.00 |
| TOTAL DIRECT EXPENDITURES | 0.00 | 0.00 | 0.00 | 0.00 |

**Illinois Grant Accountability and Transparency
Consolidated Year-End Financial Report**

| | |
|---------------------|-------------------------------|
| Program Name | All other costs not allocated |
|---------------------|-------------------------------|

| Category | State | Federal | Other | Total |
|--|--------------|----------------|----------------------|----------------------|
| Personal Services (Salaries and Wages) | 0.00 | 0.00 | 7,089,975.00 | 7,089,975.00 |
| Fringe Benefits | 0.00 | 0.00 | 36,863.00 | 36,863.00 |
| Travel | 0.00 | 0.00 | 41,179.00 | 41,179.00 |
| Supplies | 0.00 | 0.00 | 65,989.00 | 65,989.00 |
| Contractual Services | 0.00 | 0.00 | 224,932.00 | 224,932.00 |
| Consultant (Professional Services) | 0.00 | 0.00 | 281,482.00 | 281,482.00 |
| Occupancy - Rent and Utilities | 0.00 | 0.00 | 277,433.00 | 277,433.00 |
| Telecommunications | 0.00 | 0.00 | 87,475.00 | 87,475.00 |
| Direct Administrative Costs | 0.00 | 0.00 | 287,186.00 | 287,186.00 |
| Miscellaneous Costs | 0.00 | 0.00 | 4,581,051.00 | 4,581,051.00 |
| TOTAL DIRECT EXPENDITURES | 0.00 | 0.00 | 12,973,565.00 | 12,973,565.00 |



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For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 151907



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